Clinical Documentation Guideline for Nursing Facilities

Document	Federal	State	Time Frame	Comments
Client Assessment, Referral and Evaluation (C.A.R.E.)	not required	KSA 39-931a	Available at admission for persons entering Medicaid certified nursing facilities	This requirement does not apply to long term care units of hospitals. Copy of C.A.R.E. assessment and Level II assessment must be maintained on the resident's active clinical record.
Pre-admission Screening -history of falls -diagnoses -behavior wandering -cognition -environmental needs -expectations of resident and/or family -need for specialized therapy or equipment i.e. tube feedings, skin care.	not required	not required	Prior to admission to the facility	Determination whether the services required by the resident can be provided by the facility. Determination of payment sources Screening for Medicare Part A and Part B eligibility. Information can be used to complete MDS Section AB. Demographic Information and Section AC. Customary Routine.
Identification of legal representative	483.10(a)(3)(4)	28-39-147(a)	Available at admission or when implemented	A copy of the court order granting a guardianship should be maintained in an administrative file of the resident. A copy of a durable power of attorney for health care (DPOAHC) should be in an administrative file and another copy in the active clinical record. Please note that in Kansas only the resident or the resident's legal representative can sign an admission agreement and authorization for the facility to manage the resident's funds.
Advance directives	483.10(b)(4)	28-39-148(j)	At admission or when executed	Evidence that facility has discussed information on advance directives and Kansas laws related to advance directives must be documented. Copies of any advance directives executed by the resident or the resident's DPOAHC must be on file in the resident's record. Advance directives include do not hospitalize, do not resuscitate, medication restrictions, treatment restrictions, feeding restrictions, organ donation and autopsy requests.
Resident rights	483.10 483.12	28-39-147 28-39-148	Prior to or on admission and periodically during the stay	Evidence must be available that residents and/or legal representative were provided information on resident rights at admission and periodically.

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Address/phone number of resident's legal representative or interested family member	483.10(b)(11)	28-39-147(g)	At admission and periodically during stay	Staff must have ability to notify legal representative and/or interested family members when there is a change in resident's status. Record on clinical record.
Admission physician orders	483.20(a)	28-39-155(b)(1)	Before or on admission	Admission orders must state that resident is to be admitted to a nursing facility. Orders must include all necessary medications, treatments, diet, and activity needed for the resident's immediate care. Specific orders must be obtained for admission to a special care section or unit.
Medical History		28-39-155(b)(1)	Within seven days of admission	Physician must provide current medical findings and diagnosis on admission. Medical history must be provided within 7 days of admission. NOTE: A physical examination performed by a physician is **not** required.
Bed Hold Policy	483.12(b)	28-39-148(j)(3)	At admission and at time of transfer to another health care facility or when leaving facility for therapeutic leave	A copy of the bed hold policy must be provided to the resident/legal representative at admission and at the time of transfer.
Information concerning Medicare and Medicaid	483.10(a)(5)(6)	NA	At admission and when appropriate during stay	Must provide written information about Medicaid eligibility if facility is Medicaid certified. Provide written information concerning Medicare benefits, if facility is Medicare certified.
Inventory of possessions	Not required	28-39-149(d)	At admission and updated yearly	Record of inventory may be on the resident's clinical record or in an administrative file.
Choice of Pharmacy	Not required	28-39-144(e)(5)	At admission	Record the resident's choice of pharmacy in admission documents
Choice of Hospital	Not required	28-39-155(e)	At admission	Record the hospital designated by the resident and/or legal representative to which the resident is to be transferred to in an emergency.
Admission Assessment Recommend initial evaluation of the following RAI items and further assessments: -Section AC Customary routine -E4aA Wandering	483.20	28-39-151	On day of admission	The information process for completing the comprehensive assessment must begin on the day of admission. Avoid using long narrative progress notes. A facility specific assessment for new admissions should be developed. Information can be transferred to the MDS. The initial assessment on the day of admission is the most important assessment performed during the resident's stay.

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-G1aA Bed mobility -G2 & G3 Balance test for sitting and standing -G6a Bedfast -H1a Bowel incontinence/fecal impaction -H1b Urinary incontinence -I1j Peripheral vascular disease				Use the assessment to baseline the resident's current physical, mental and psychosocial status and status prior to hospitalization or events which necessitated admission.
-J2 & J3 pain -J4a Fell in last 30 days -J4b Fell in last 31-180 days -J1f Dizziness				Perform standardized pain assessment. See reference page for resources for pain assessment. Assess new residents for risk for falls, using a standardized instrument, on the day of admission. Review falls RAP and complete pertinent items on MDS. Begin falls prevention program on the day of admission. Include Sections G2 and G3 in assessment.
-M2a Pressure ulcer -M3 History of pressure ulcers -M4e Skin desensitized				A registered nurse should complete a standardized skin assessment on the first day of admission and again on the last day in the assessment reference period to ensure that all areas with potential risk have been identified. Focus on bony prominence and heels. Ensure that any skin problems are described and identified as to cause on the clinical record.
-04a anti-psychotic drugs -04b anti-anxiety drugs -04c anti-depressant drugs -P4 Devices & restraints -P4c Restraints				Request physician documentation to support findings of nursing staff. Implement skin protocol immediately based on the level of risk identified. (See reference page for resources for standardized skin assessment scales.) Ask about the use of food supplements and herbals. Medication history for previous three months. Ask about compliance with physician orders while at home.
-Risk for elopement			Day of Admission	Any resident with a history of wandering, cognitive impairment, and poor decision making should be assessed for risk of elopement on day of admission. If determined to be at risk, a plan should be implemented immediately.

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-Social Services	483.20	28-39-151	Within 14 days of admission	Social service documentation to baseline behavior at home; discussion with family and/or friends of issues related to admission; past coping mechanisms, support system; significant losses; what gives the resident enjoyment and spiritual support; and unmet. Standardized form or a narrative format. Record discussion concerning Durable Power of Attorney for Health Care; advance directives; unmet needs and plans for discharge. Document resident's/ family/legal representative's goals if appropriate.
-Nutritional assessment Current weight, height, and usual weight, food allergies. Usual food and fluid intake	483.20	28-39-151	Within 14 days or earlier if at risk for malnutrition	Dietitian and/or dietary manager begins nutritional assessment on day of admission. Nurse or dietitian should assess each new resident for the risk of malnutrition and dehydration on the first day of admission. Residents who are fed via an enteral tube should be assessed by a dietitian on the day of admission. This can be a telephone consultation between the dietitian and the nurse performing the assessment. Ask for information on food allergies. Specific procedure should be written and implemented to accurately determine height and weight. Weights should be done at least monthly. Recommend verbally weights for four weeks on all new admissions. Height should be rechecked at least annually. Dietitian should be consulted for residents who have had a limb amputated to determine weight/weight loss. Record accurately the percentage of food and fluid intake for residents at risk for malnutrition and dehydration for at least the first three days of admission. See reference page for information on nutritional assessments.
Restorative Nursing	483.20	28-39-151	Within 14 days of admission	Each resident should be assessed by a licensed nurse for the need for a restorative nursing program. A physician's order is not required for a restorative nursing program. Restorative nursing programs must meet the requirements found on pages 3-153 and 3-154 in the Long Term Care Resident Assessment Instrument User's Manual (RAI).

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Head to toe physical assessment performed by registered nurse	Not required	Not required	Within 3 days of admission	Use a standardized physical assessment form which includes a review of all systems. Record deviations from normal. NOTE: Each resident should be reassessed on the first day after return from a transfer to a health care facility or from therapeutic leave.
Head to toe physical assessment performed by registered nurse (Continued)				Nurse should review most recent assessment and determine if the resident has experienced a significant change in condition. Record rationale for conducting or not conducting a significant change in condition. See page 2-12 of RAI manual.
Significant change in Condition Assessments	483.20(b)(2)(ii)	28-39-151(b)(2)	Within 14 days of the change in condition.	A system should be developed to identify residents promptly when a significant change in condition may have occurred. The criteria is found on pages 2-8 through 2-11 in the RAI manual. When a resident returns from a hospital stay, a registered nurse should evaluate the resident's current condition and compare findings with the most recent comprehensive assessment. If findings indicate that the resident has not met the criteria for a significant change in condition, the rationale for this decision should be documented in the resident's clinical record. If the resident meets the criteria, an assessment reference date should be established for the significant change in condition assessment. A change in source of payment from private pay, private insurance or Medicare does not in itself require a significant change in condition assessment. If the resident becomes eligible for Medicare Part A, follow Medicare PPS rules. Residents who go on temporary or therapeutic leave should be reassessed by a licensed nurse on return to the facility. If a significant change in condition occurred, begin a comprehensive assessment. Record rationale for decision in clinical record.
Annual Assessments	483.20(b)(2) (iii)	28-39-151(b)(3)	No more than 365 days between comprehensive assessments	There should not be more than 365 days between VB2 dates. A significant change assessment resets the date the annual assessment is due. See page 2-7 in the RAI manual.
Discharge Tracking Assessments	RAI manual pages 3-2 and 3-3			Develop procedure for encoding and sending discharge tracking forms. Emphasize operational definitions for "return anticipated" and 'return not anticipated."

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Scheduling MDS Assessment				RAI coordinator determines assessment reference date (ARD) on day of admission or first working day. All staff who are responsible for completing a portion of the MDS must be informed of the ARD. Events which occur after the ARD cannot be included on the assessment.
Scheduling MDS Assessment (Continued)				A specific scheduling system is available to ensure that assessments are performed in a timely manner. Staff responsible for completing the MDS are informed of assessment due date in a timely manner. Training and retraining should be available for all staff who complete a portion of the MDS. Each staff member should have a personal copy of the RAI manual or copies of the sections which they are responsible. Competency in completing the MDS accurately should be evaluated before a staff person is allowed to perform part or all of the assessment.
Quarterly Assessments	483.20(c)	28-39-151(c)	Quarterly assessments must be completed within 92 days of the R2b date.	Facilities may choose to perform the three page RUGs III quarterly or a full assessment. Each resident should be evaluated for significant change at the time a quarterly assessment is conducted. See page 2-13 in RAI manual. Note: It is estimated that approximately 25% of nursing facility residents will experience a significant change in condition each Quarter. Check facility Quality Indicator reports.
Resident Assessment Protocols	RAI manual pages 4-1 through 4-23	RAI manual	Completed with admission assessment, significant change in condition and annual assessment	It is not necessary to record all items referred to in RAP Guidelines - page 4-10 in RAI manual. For examples of RAP documentation see pages 4-11 through 4-15. Reviews of RAPs previously triggered RAPs see page 4-12. When RAPs are not enough see pages 4-18 and 4-19.
Comprehensive Plan of Care	483.20(k)	28-39-151(h)	Complete 7 days after RAPs completed. Review and revise as necessary each time a quarterly assessment is performed.	See pages 5-1 through 5-10 in RAI manual. Comprehensive care plan must reflect the findings identified in the MDS and RAPs process as well as other information concerning the resident. There is no requirement that a meeting be held, but there must be evidence that the interdisciplinary team was involved in the development of the plan.

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Comprehensive Plan of Care (continued)			The care plan maybe revised at any- time deemed necessary by a member of the care team	There is no requirement that care plans be signed. A care plan is the reflection of the staff's intent to meet the needs of each resident. Any member of the care planning team may sign the MDS at VB3. The effect of the care plan on the resident must be evaluated and documented at least every three months. The facility should have a policy and procedure for the development and revision of care plans. System must be in place to communicate the care plan interventions to staff. Federal and state regulations require that the care plan include measurable objectives and time frames. The plan must describe the services to be furnished and services which the resident refuses under resident rights.
Qualifications of staff who complete RAI	RAI manual page 2-16	RAI manual page 2-16	RAI must be completed by qualified health professionals	The facility is responsible for ensuring that the persons who complete the MDS and RAPs are qualified and competent. A registered nurse may complete all sections. Other sections can be completed by qualified health care professionals. Sections E and F can be completed by a social worker and by an individual who meets the requirements found at KAR 28-39-144(ccc)(2).
Qualifications of staff who complete RAI (continued)				Section K can be completed by a licensed dietitian or a licensed nurse. A dietary manager who has been found to be competent by the consultant dietitian may complete Sections K2.3.4.5. Section N can be completed by any activity staff deemed competent by facility. Section P2. Professional therapy staff may complete section or provide information to RAI Coordinator.
Storage of RAI	RAI manual page 2-18	RAI manual page 2-18		Records related to the RAI process for the previous 15 months must be available to staff and surveyors. RAI records can be in a clinical chart, a notebook or file at the nurses' station. RAI documentation cannot be stored in a locked office. See page 2-18 in RAI manual.
Physician Orders	483.40(a)	28-39-155(2)	Immediately on receipt	A licensed nurse must implement physician orders. The nurse must sign and date all orders. Under the supervision of a licensed nurse, medication and treatment orders can be written on the MAR and/or treatment sheet by unlicenced staff.

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Verbal orders		28-39-156(b)(4)	Within seven days of the order.	Verbal orders for drugs must be taken by a licensed nurse. Physician must sign the verbal order within seven days.
Resident Refuses physician orders	483.10(a)(4)	28-39-147(d)(3)	Record at the time of refusal	Residents have the right to refuse treatment. When medications are refused, document the refusal and reason, if known, and report to physician. Record the report provided to the physician and the physician's response. It is appropriate to educate the resident/legal representative of the possible outcomes when ordered medication and treatment are refused. Document the discussion with resident/legal representative.
Progress Notes	483.75(1)	28-39-163 (m)(D)	Ongoing	The progress notes written by each health care professional and other direct care staff as determined by the facility should reflect the care and services based on the complete care plan provided to the resident and the resident's response.
Physician Progress Notes	483.40(b)(e)	28-39-155(b)(d)	At each visit	The physician must write, sign and date a progress note at each visit. There should be evidence that the physician reviewed the resident's medications, treatments and comprehensive care plan. Progress notes for visits delegated by the physician to an advanced registered nurse practitioner or a physician's assistant must meet the requirements stated above. There is **no** requirement that a physician co-sign progress notes written by a physician extender. When residents go to a physician's office it is recommended that a report which includes a list of current medications and treatments, a review of resident's response to current care plan and other pertinent information concerning the resident's status. Provide space on this form for new orders and a progress note or send an order sheet and progress note sheet for the physician to complete.

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Direct Care Staff Documentation		28-39-163(m) (6) (J)	Ongoing	Document of all incidents, symptoms, and other indications of illness or injury including date, the time of occurrence, the action taken, and the results of the action. Each facility may develop their own system for recording incidents and symptoms. FOCUS charting, charting by exception, and other systems maybe used as long as the documentation reflects the requirements found in the regulations. All direct care staff including nurse aides and medication aides may document in a resident's clinical record. This decision is determined by facility policy. Flow sheets should be designed to reflect the resident's care plan and be outcome oriented.
Medication Administration Record (MAR) Treatment documentation		Immediately before or after admission		The label on the drug container, physician order and directions on the MAR must match. A licensed nurse may add additional explanatory information on the MAR to ensure appropriate administration by medication aides. A licensed nurse should review the MARs at least once a month to ensure accuracy with physician orders. Note: Staff should initial MAR immediately after administering a medication. It is also acceptable to initial the MAR immediately prior to administration of a drug if each resident's drugs are set up and immediately administered. If the resident refuses the medication, staff should circle initials and record reasons for refusal in clinical record. If the treatment is ordered by a physician the treatment record must be recorded exactly as the physician ordered. Record location, time and what was done.
Reports of consultants	483.75(j)(k)	29-39-163(j)(k)	Immediately after completing the treatment	Place in record. Document how attending physician was notified of report and any orders received from the attending physician to implement plan of treatment recommended by consultant. Reports of consultants cannot be copied and sent to another health care setting without the consultant's written permission
Laboratory, X-ray and other diagnostic reports		28-39-155(f)		Document how the attending physician was notified of the report, his/her response to the report and any new orders resulting from notification of these results. Place the report in the record only after the physician has acted it upon. If the physician prefers these reports to be faxed to his/her office; document date and time the report was faxed.

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Laboratory, X-ray and other diagnostic reports (continued)				If the lab results were not within normal limits and the physician has not acknowledged receipt of the reports relax or call the office as deemed clinically appropriate. The Administrator and/or DON should immediately be notified of any failure to obtain response from the physician regarding reported abnormalities or concerns regarding clinical status.
Transfer to another health care facility	483.12(b)	28-39-148(j)(3)	Prior to transfer	Provide copy of bed hold policy to resident and/or legal representative or family member if known. Record the resident's status at the time of transfer and reason for transfer. Prepare transfer document according to facility policy. Transfer document should include current diagnoses, medications, treatments, identification of changes in status which necessitated transfer. Record physician order for transfer and reason. Record mode of transportation date and time. Copies of advance care planning documents including do not resuscitate order, living will and durable power of attorney for health care should be included with transfer documents. Record name and telephone number of legal representative or family member if available on transfer form. Record notification of resident/family/ responsible party of transfer and their response. Planned transfers should include a review of cognition, psychosocial, mental state, nutritional status, functional status, and skin assessment.
Discharge Summary	483.20(1)	28-39-151(j)	At discharge	Prior to discharge to another nursing facility, assisted living/residential health care or other adult care home, home health agency or to own home, the facility must prepare a discharge summary. The summary is intended to provide a recapitulation of the resident's stay and response to the treatment and services provided. This summary is to be provided to authorized persons and agencies with the resident's or legal representatives permission to ensure continuity of care. Discharge planning should begin as soon as it is determined that resident will go to another setting. NOTE: A discharge summary is not required for a resident who dies in the facility or dies during hospital stay.

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Discharge Plan of Care	483.20(1)(3)	28-39-151(j)(3)	At discharge	Discharge plan of care should include referrals to other agencies for post discharge care. There should be evidence that the resident, legal representative and if appropriate, family were involved in the development of the plan. Physician instructions for medications and treatments should be documented with specific instructions by the appropriate discipline such as nursing, dietary, therapy and social services.